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Readiness Of The Medical Record Unit To Face The Accreditation Process At The Clinic

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ABSTRACT

RSU Wisata UIT is a health facility in Makassar City that offers first-rate health services to the community, including 4D ultrasound with AI to monitor pregnancy, and serve patients from inside and outside the city. Efforts that can be made to improve the quality and safety of clinical services in primary clinics are through accreditation. The medical record unit is part of the service support unit at the primary clinic which is included in the assessment of the accreditation of the primary clinic. The readiness of the medical record unit needs to be assessed to see what documents and implementation do not yet exist. The identification of the readiness of the accreditation of the medical record unit of Clinic X had been carried out two years earlier, namely in 2021. This study aims to find out how the continuation and readiness of the accreditation of the medical record unit will be in 2024. This research method uses an observational descriptive approach through a cross sectional design. The research data was collected through observation and interviews with medical record officers, then analyzed by comparing the predicted score of the accreditation readiness score of the clinical medical record unit X in 2021 with 2024. The results show that the readiness for accreditation for clinical medical record units X in 2024 has increased, from a predicted score in 2021 of 41.7% to 65.8% in 2024. With the comparison of accreditation readiness, it can be used as evaluation material to meet the needs of both the documentation that has not been ready and the procedures that have never been implemented. From the results of this study, it can be concluded that the achievement of accreditation assessment has not been maximized due to almost all assessment indicators that have not been possessed, including the availability of supporting documents. Clinics that can create a frame of reference first, by determining methods and analyzing instruments that are in accordance with the method used.

Keywords: Accreditation, primary clinic, medical records.

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INTRODUCTION

Clinics are the main door in providing clinical services to the community. The provision of safe and quality health services requires the development of a clinical service system that can minimize errors in measurement, monitoring, control, maintenance, and documentation of clinical service processes and service management that are not optimal, as well as continuous improvement of service systems that are not running. This can be overcome by standardizing the quality management system and clinical service system that are followed up with continuous quality improvement, as well as the implementation of patient safety rules.

In an effort to improve the quality of services, it is important to improve the quality of services in the health sector. Improving the quality of health is not an easy thing because it does not only apply to advanced health facilities such as hospitals, but also applies to all levels of basic health

services, namely health centers. BUK (Bina Upaya Kesehatan) of the Ministry of Health stated that the indicator of the quality of health services is accreditation. The purpose of accreditation is so that health services have quality and are able to provide quality services according to standards. The quality of health services must be carried out in accordance with the set service standards so as to cause satisfaction for each patient. Efforts to ensure the quality of a clinic can be carried out by including clinics in the accreditation of primary clinics. Accreditation aims to improve service quality continuously in accordance with service standards. Klinik X in 2021 has conducted an accreditation assessment trial on all units. The medical record unit is one of the units that plays an important role starting from registration to recording the patient's disease history. The assessment of the accreditation of primary clinics is carried out as a continuous quality assurance effort. Therefore, this study aims to determine the progress of the readiness of the medical record unit in facing accreditation so that it becomes a reference for the medical record unit of Clinic X before the implementation of accreditation

METHOD

This research is a type of observational descriptive research using a quantitative approach, with a research design in the form of a cross sectional design. Data collection was carried out at Clinic X in January-February 2024. Using research instruments that refer to the regulation of the Minister of Health Number 46 of 2015 through observation and interview techniques. Conducting observations with assessment guidelines and document searching, assessment elements are adjusted to accreditation standards. Documents are broadly divided into two parts, namely internal and external documents. The internal documents are in the form of policies, guidelines, and Standard Operational Procedures (SOP), while external documents are laws and regulations and several applicable external guidelines (regulations).

Data collection through interviews is carried out to clarify the results of searching for unknown documents. Interviews were conducted with the executive officer of the medical records section of Clinic X with a sample of 6 people including administrators and medical personnel. The medical record unit has 16 assessment elements in accordance with PMK Number 46 of 2015 concerning accreditation. Checking the assessment elements was carried out by the researcher in preparation for accreditation of the medical record unit. The assessment is categorized into 3 elements, namely fulfilled, partially fulfilled and unfulfilled. The division of categories is carried out to make it easier to assess achievements. Category classification and category conversion based on PMK no. 46 of 2015. The category is converted in values of 0 (not fulfilled), 5 (partially fulfilled), and 10 (fulfilled). The assessment element of the accreditation standard can be in the form of documents.

The first category is that the document does not exist and has not been fulfilled, then in the score prediction column 0 is filled in (not fulfilled). The second category is that the document exists and has not been fulfilled or vice versa, then in the score prediction column 5 is filled in (partially fulfilled). The third category is that the document exists and has been fulfilled, then in the score prediction column 10 is filled in (fulfilled). The assessment results are summed up into the total score of the overall elements, then identified through the percentage of achievement divided into categories of < 20% (not fulfilled), 20%-79% (partially fulfilled), and > 80% (fulfilled).

FINDING AND DISCUSSION

The accreditation process is a means to build standard promotions but can optimize and improve processes and outcomes in health services. Patient satisfaction can be evaluated using a fixed accreditation system is a vital outcome to assess. Standards can be promoted and recommended by national accreditation systems, thus providing an incentive for patients in healthcare to collect and report patient satisfaction. National data on patient satisfaction mentions policies at the system or organizational level, quality improvement and HR skill level aimed at helping the progress of health care facilities (Haj-Ali, Karroum, Natafgi, & Kassak, 2014). Accreditation based on Permenkes Number 46 of 2015 concerning Accreditation of Health Centers, Primary Clinics, Independent Practice Places for Doctors, and Independent Practice Places for Dentists is a recognition given by the Accreditation Implementation Institution determined by the minister after meeting the accreditation standards. The main purpose of accreditation is to foster quality improvement, performance through continuous improvement of the management system, quality management system and clinical service delivery system, as well as the implementation of risk management, and not just an assessment to obtain an accreditation certificate. The combination of accreditation and certification is a stronger predictor of quality management at the service level than assessments in isolation, thus suggesting that accreditation and certification are both beneficial. (Shaw et al., 2014).

The accreditation process involves assessments on a specific set of standards, on-site surveys by peers from external organizations trained in assessment, assessment of the level of conformity to the standards, written reports with or without recommendations and granting or refusing status. The main accredited healthcare services are in Canada, the United States, Australia, New Zealand, the United Kingdom, and the Netherlands, with Denmark launching programs owned by them in the next year or two. Since this review was completed, a study highlighting the accreditation of different schemes for primary care practices in Europe has been published. To date, primary service accreditation is mostly non-government-funded, a voluntary process with some countries offering financial incentives. The United States, Australia and Canada are most influential in the development of primary care accreditation worldwide, with many standards highlighting

patient-centered services (O'Beirne et al., 2013). Healthcare organizations must have medical records that are administratively responsible for recording patients' health histories. Medical records must be in place for each individual evaluated or treated in a healthcare organization. Medical records include at least written documents, computerized electronic information, radiology films and scans, laboratory reports and pathology slides, videos, audio recordings, and other forms of information related to the patient's condition (Back, 2011).

Medical records should be appropriate to the scope and complexity of the healthcare performed. Healthcare organizations must employ adequate personnel to ensure prompt completion, filing, and note-taking. Medical record services must be regulated, equipped, and managed in accordance with the scope and complexity of health organization services, there must be a medical record SOP for medical record officers to ensure the completeness of filling out medical records. The completeness of the filling must be carefully considered, starting from the patient's identity, anamnesis, diagnosis, actions and medications given. The medical record filing system also needs to be considered, storage is grouped according to the type of patient and in a safe storage place so that medical record files are not damaged or lost. The medical record collection system needs an SOP so that not just anyone can take the patient's medical record file, after taking the medical record immediately to be returned within 1 time 24 hours so that the file is not lost (Dasilveira, 2002).

Storage and destruction of medical records according to AACI Standards, that is, healthcare organizations must keep medical records for each inpatient and outpatient. Medical records must be accurate, clear, and complete, promptly completed, properly filled out and stored, and accessible. Each medical record should be complete with all documentation, diagnosis, evaluation, treatment, test results, treatment plan, discharge plan, approval, intervention, discharge summary, and treatment provided along with the patient's response to such treatment, intervention, and treatment (Dasilveira, 2002). Healthcare organizations must have a medical record system that allows the medical records of each patient, inpatient or outpatient, to be evaluated and/or treated at each organization's healthcare location in the last 5 years to be accessible to the right staff, 24 hours a day, 7 days a week, whenever the medical records are needed (KKI, 2006). Medical records must be properly stored in a safe location where they are protected from fire, water damage, and other threats. The medical record system must ensure that medical record entries are not lost, stolen, destroyed, altered, or reproduced in an unauthorized manner (KKI, 2006).

Healthcare organizations must have a patient identification and record maintenance system that ensures the integrity of authentication and protects the security of all record entries. The medical record system must correctly identify the patient from each medical record entry and must protect the security of all medical record entries. Confidentiality of patient medical records according to AACI Standards as follows: Healthcare organizations must have procedures to ensure

the confidentiality of patient records. Information from, or copies of records, may be released only to authorized individuals, and healthcare organizations must ensure that unauthorized individuals cannot access or alter patient records (Dasilveira, 2002). Patient records must be secure at all times and in all locations. This includes open patient records for patients who are currently inpatients in healthcare organizations and outpatients in outpatient clinics. The contents of the patient's medical record according to the AACI Standards must include medical records must contain information to justify acceptance, support the diagnosis, and describe the patient's health progress towards drugs and services. All writings must be legible, complete with dates and times. They must be authorized by the person responsible for providing care consistent with the health care organization's policies. Medical records should contain information such as records, documentation, records, record reports, test results and assessments to support the diagnosis and describe the patient's progress and response to medications and services.

The medical record must contain complete information or documentation regarding the evaluation, intervention, care provided, services, treatment plan, discharge plan, and patient response to those activities. The comorbidities identified in the patient's record should be considered and treated as necessary in the patient's overall field of care. When electronic medical records are used, healthcare organizations must demonstrate how to prevent changes to record entries after they have been authenticated. The information needed to review electronic medical records, including the codes and security features concerned, should be available to surveyors to enable them to review the medical records of the sample while on-site in the healthcare organization (Dasilveira, 2002).

A practitioner must review and certify all electronic records or otherwise to prevent him or her from mistakenly receiving documents that may be automatically confirmed without a doctor's review. The practitioner must separately have the date and time his signature authenticated an entry, even though there may already be a date and time on the document, as the latter may not reflect when the entry was confirmed. For certain electronically generated documents, where the date and time examined by a physician, an electronic transcription of the document is automatically printed, the requirements of this section will be met.

However, if electronically created a document only prints the date and time of the event (e.g., ECG prints, lab results, etc.) and does not print the actual date and time reviewed by the practitioner of the document, then the practitioner must authenticate, date, and time this document itself or include an acknowledgment that the document was reviewed into another document (such as H&P, progress records, and others), which will then be authenticated, dated, and given a deadline by practitioners (KKI, 2006). All patient records, both inpatient and outpatient, should contain the results of all consultative patient evaluations and appropriate findings by clinical and other staff involved in the care of the patient. This information should be immediately submitted in the

patient's medical record to be available to physicians or other care providers to use in making patient assessments Preparatory efforts that can be made toward accreditation are through Workshops. This effort is the earliest stage carried out by the accreditation assistance team.

The stages of the workshop were an understanding of the accreditation policy and building the commitment of the leadership and all staff to assist in accreditation. The accreditation standards for primary clinics are arranged in 4 Chapters, namely Chapter I Clinical Leadership and Management (KMK), Chapter II Patient-Oriented Clinical Services (LKBP), Chapter III Clinical Service Support Management (MPLK), and Chapter IV Improving Clinical Quality and Patient Safety (Ministry of Health of the Republic of Indonesia, 2014). Each chapter has several standards consisting of its own criteria and assessment elements. The assessment of medical record accreditation in the primary clinic accreditation standards is found in Chapter II and Chapter III. Chapter II on Patient-Oriented Clinical Services (LKBP) consists of 10 standards divided into 34 criteria. The total number of assessment elements of the criteria is 151 elements. The accreditation standards in this chapter are regarding service standards from registration to repatriation and follow-up. Chapter III accreditation standards regarding Clinical Service Support Management (MPLK) are seven with a total of 35 criteria. The total assessment elements amounted to 172 elements. The standards in this accreditation discuss the supporting services in the clinic to its management, both equipment and other resources owned (Anggraeny & Ernawaty, 2016).

Table 1. Comparison of the Results of the Achievement of Accreditation Readiness for Clinical Medical Record Unit X in 2021 and 2024 according to the Minister of Health Regulation No. 46 of 2015

		Persentase Pencapaian	
No	Kriteria Penilaian	2021	2024
1	The results of the study are recorded in medical records and easily accessible to the officer responsible for patient care	33,3%	66,7%
2	There is a standard of diagnosis classification codes, procedure codes, symbols, and terms used	75%	62,5%
3	Officers have access to information according to their needs and job responsibilities	100%	100%
4	The existence of a system that guides the	0%	50%

	storage and processing of medical records		
5	The record contains adequate and confidential information about patient identification, documentation of study procedures, problems, patient progress and care outcomes	0%	50%
	Total Achievements	41,7%	65,8%

Sumber : *Self assessment* diolah peneliti, 2024

Clinic X will face accreditation in 2024. The preparations made range from the completeness of documents, infrastructure, to the quality of service and patient safety at the clinic. The medical record unit is under the management of the driver's license and the administration also participates in preparing accreditation. The elements of the accreditation assessment of medical record units are found in Chapter II, namely Patient-Oriented Clinical Services (LKBP) and Chapter III, namely Clinical Service Support Management (MPLK).

This identification is carried out to find out the extent of the readiness of Clinic X, especially in the Medical Record Unit in facing Primary Clinic Accreditation. Identification was carried out by observation methods and interviews with several medical record officers. This identification table is compiled based on the guidelines for the accreditation assessment of primary clinics complete with the required document criteria. The medical record unit has 16 assessment elements in accordance with PMK No. 46 of 2015 concerning accreditation. The assessment is categorized based on accreditation standards, namely < 20% not met, 21-79% partially fulfilled and > 80% fulfilled.

The criteria for the assessment elements of the medical record unit are based on PMK No. 46 of 2015 concerning Accreditation there are five criteria and 16 assessment elements. The first criterion contained in chapter 2 regarding medical records is that the results of the study are recorded in medical records and easily accessible by the officer responsible for patient services. The purpose of this criterion is to ensure the continuity of services, so the results of the study are recorded in the patient's medical record. The information contained in the medical records must be easily accessible to the officer responsible for providing services to the patient, so that the information can be used when needed to ensure continuity for the patient's treatment and safety.

The findings of the initial examination can be used to establish a diagnosis and establish services or actions as needed as well as a follow-up and evaluation plan. Preliminary findings and studies can also be used to decide whether a review is needed in a dubious situation. Therefore, it is very necessary that medical studies, medical supporting studies, nursing studies and other meaningful

studies, are well documented. The results of this study should be quickly easily rediscovered in medical records or from other locations specified by standards and used by staff serving patients.

The results of the identification of the accreditation readiness of the medical record unit of Clinic X showed that the assessment element of the study results was recorded in medical records and easily accessible by the officer responsible for patient services. There are three indicators, each of which has special document requirements that must be completed during primary clinic accreditation.

The first indicator is to identify what information is needed in the assessment and must be recorded in medical records. In this indicator, a document is needed in the form of an initial study SOP that contains what information must be obtained during the assessment process (the clinical service team needs to determine what information needs to be included in the patient's medical record). This document in 2021 was not owned by Clinic X, but in 2024 it already existed, but it has not been ratified, so that in the indicator it will get a score of 5 in 2024.

The second indicator is medical record information including information needed for medical studies, nursing studies, and other necessary studies, In this indicator, a document is needed in the form of an initial study SOP that contains what information must be obtained during the review process. This document in 2021 was not owned by Clinic X, but in 2024 it already existed, but it has not been ratified, so that in the indicator it will get a score of 5 in 2024.

The third indicator is coordination with other health workers to ensure the timely acquisition and utilization of this information to serve patients. The documents needed are not mentioned in this indicator, but can be proven by minutes during meetings or employee attendance. In 2021 and 2024, Clinic X will always use minutes and attendance during meetings so that it gets a score of 10.

The results of the achievement of the assessment element score of the study results are recorded in medical records and are easily accessible to the officer responsible for patient services in 2021 by 33.3% and in 2024 by 66.7%, the achievement is still included in the partially fulfilled category. The results of the assessment are partially fulfilled, meaning that there are still several documents that must be fulfilled such as the SK document and the initial patient study SOP. The documents in the assessment element must be fulfilled so that the accreditation score in this assessment element is maximized or fulfilled.

The second criterion is that there is a standard code for diagnosis classification, procedure codes, symbols, and terms used. The purpose and purpose of the criteria is the standardization of terminology, definition, vocabulary and naming to facilitate the comparison of data and information inside and outside the clinic (referral clinic). Uniformity of use of diagnostic codes and codes of procedures or actions supports data collection and analysis. Abbreviations and symbols are also standardized and include a "not to use" list. The standardization is in accordance with applicable local and national standards.

This element has 4 indicators. The first indicator is that there is a consistent and systematic standardization of diagnostic classification codes and other terminology. The document needed in this indicator is a decree on the standardization of diagnostic classification codes and terminology used. In 2021 and 2024, SK has been owned by Klinik X but is still in the form of a softfile. So that this indicator gets a value of 5.

The second indicator is that there is a standardization of diagnosis classification codes and terminology compiled by clinics (at least the top 10 diseases). The documents needed are in the form of standardization of diagnostic classification codes and terminology in health care facilities. In 2021 and 2024 the document has been owned by Clinic X. The use of ICD X disease standardization has resulted in a score of 10.

The third indicator is the standardization of abbreviations used in services in accordance with national or local standards. The documents needed are in the form of abbreviations used and medical record service standards. In 2021 and 2024, the document has been owned by Klinik X. Abbreviation standardization has been carried out, but the standard service document is still in electronic form. So that it gets a score of 10.

The fourth indicator is the establishment of policies and procedures for officers' access to medical information. The documents needed are in the form of a decree and SPO regarding access to medical records. Based on the results of the accreditation assessment in 2021, this document exists, but in 2024 this document was not found, causing a decrease in the score in 2021 with a score of 5, and in 2024 with a score of 0.

The results of the achievement of the score of the assessment elements are the standardization of diagnostic classification codes, procedure codes, symbols, and terms used in 2021 of 75% and in 2018 of 62.5% This achievement is still included in the category of partially fulfilled. The decrease in accreditation progress in this element may be due to missing documents. Therefore, a special team is needed to prepare for accreditation, especially in the medical record unit. The team will later identify the need for documents according to the elements of the accreditation assessment. Documents that do not yet exist must be completed immediately before the implementation of accreditation.

The results of the achievement of the score of the assessment elements are the standardization of diagnostic classification codes, procedure codes, symbols, and terms used in 2021 of 75% and in 2018 of 62.5% This achievement is still included in the category of partially fulfilled. The decrease in accreditation progress in this element may be due to missing documents. Therefore, a special team is needed to prepare for accreditation, especially in the medical record unit. The team will later identify the need for documents according to the elements of the accreditation assessment. Documents that do not yet exist must be completed immediately before the implementation of accreditation.

Chapter III in the assessment element of access to medical records in 2021 there is an SOP document for access to medical records, but in 2024 the document will not be found, because the document is missing. In addition, regarding the medical record storage and processing system in 2021, there are no SOP or standardization documents, while in 2024 there will be a document regarding the identification of medical record classifications that are differentiated by the color of patients' medical records based on the type of general patient, student, or BPJS. The provision of disease classification codes in 2024 has used ICD-10 and there has been a reference in the form of a soft file that has not been ratified. The progress of the readiness of accreditation of medical record units in Chapter III shows an increase in the number of documents that have been made in 2024.

In the element of assessment that officers have access to information according to their needs and job responsibilities, there are 3 indicators that must be met. The first indicator of officers' access to the information needed is carried out in accordance with their duties and responsibilities. The documents needed are in the form of SOP for access to medical record information so that in 2021 and 2024 the same score will be 10. The second indicator is that officers' access to information is carried out in accordance with policies and procedures, the required documents exist, and have been implemented in accordance with policies and procedures. So that in 2021 and 2024 it will get the same score, which is 10. The third indicator is the right to access the information considering the level of confidentiality and security of the information. The required documents do not exist, only the SOP regarding confidentiality already exists but has not been ratified. In the assessment element, it has been explained that the documents needed are in the form of an SOP for the confidentiality of medical records, at the time of self-assessment the SOP already exists and is sufficient to replace the required documents. So that in 2021 and 2024 it will get the same score, which is 10.

The results of the achievement of the score of the assessment element of the officer having access to information in accordance with the needs and responsibilities of the job in 2021 and 2024 are 100%, the achievement is included in the fulfilled category. In this element of assessment, all indicators have been fulfilled both in 2021 and 2024. The document must be maintained intact until the implementation of accreditation. Even though it has been fulfilled, a review of the existing documents must still be carried out. If there is a need for an update, an update of the document can be made in accordance with the existing decree.

In the assessment element of the existence of a system that guides the storage and processing of medical records, there are 3 indicators. The first indicator is that the clinic has a medical record for each patient with a standard identification method. The documents needed are in the form of a medical record service decree and identification method. In 2021 there was no decree regarding medical record services, but in 2024 the decree has been made just to be ratified, so that in 2021 it will get a score of 0 and in 2024 it will get a score of 5.

The second indicator, namely the coding, storage, and documentation system, makes it easier for officers to find patient records in a timely manner and to record the services provided to patients. The documents needed by the Decree on the coding, storage, and documentation system of medical records in 2021 there is no Decree regarding medical record services, but in 2024 the Decree has been made and only needs to be ratified. In 2021 it obtained a score of 0 and in 2024 obtained a score of 5.

The third indicator is the policy and procedure for storing medical record files with clarity on the retention period in accordance with applicable laws and regulations. The documents needed are policies and procedures for storing medical record files with clarity on the retention period in accordance with applicable laws and regulations. The SOP regarding the storage and destruction of medical records does not exist in 2021, while the SOP already exists in 2024 even though it has not been ratified, so that in 2021 it will have a score of 0 and in 2024 it will get a score of 5.

The results of achieving the score of the assessment element are the existence of a system that guides the storage and processing of medical records in 2021 by 0% and in 2024 by 50%. Achievements in 2021 have not been fulfilled, while in 2018 it is still included in the category of partially fulfilled. In 2021, there are still no documents that are in accordance with the elements of accreditation assessment such as SK and SOPs, in 2024, several SKs and SOPs already exist but have not been ratified. The SOPs that have been made are still in the revision stage. The process to meet the other 50% is in the preparation stage so that at the time of accreditation, the documents already exist and are ratified.

In the element of medical record collection containing adequate information and maintaining confidentiality about patient identification, documentation of study procedures, problems, patient progress and care outcomes, there are 3 assessment indicators. The first indicator is the content of the medical record including diagnosis, treatment, treatment results, and continuity of care provided. The documents needed are in the form of a decree on the contents of medical records. In 2021, there has been no decree on the content of medical records, but in 2024 a decree has been made, only to be ratified. So that in 2021 it will get a score of 0 and in 2024 it will get a score of 5.

The second indicator is the assessment and follow-up of the completeness and accuracy of the content of medical records. Documents required SOP for assessment of the completeness and accuracy of the content of medical records, evidence of the implementation of assessments, results and follow-up assessments. In 2021 this SOP does not exist yet, it has been made in 2024 but has not been ratified so that it gets a score of 0 in 2021 and a score of 10 in 2024.

The third indicator is that there is a procedure for maintaining the confidentiality of medical records. Documents required SOP Confidentiality of medical records. In 2021 the SOP did not exist, but in 2024 the SOP regarding the confidentiality of medical records has been made and has not been ratified so that in 2021 it will get a score of 0 and in 2024 it will get a score of 10.

The results of achieving the score of the record assessment element containing adequate information and maintaining confidentiality about patient identification, documentation of study procedures, problems, patient progress and care outcomes in 2021 are 0% and in 2024 50%. This achievement is still included in the partially fulfilled category. In 2021, there are still no documents that are in accordance with the elements of accreditation assessment such as Decrees and SOPs. In 2024, several decrees and SOPs already exist but have not been ratified. The SOP for the confidentiality of patient medical records that has been made is still in the revision stage. The process to meet the other 50% is in the preparation stage so that at the time of accreditation, the documents already exist and are ratified.

The total score of achievement of accreditation readiness is still partially met, some medical record procedures still exist that have not been implemented in accordance with the standard accreditation criteria of the medical record unit. As for documents, there are several SOP and SK documents that do not yet exist so they are still included in the partially fulfilled category. In the 4th and 5th inspection elements, there was a significant increase from 0% to 50%, likely because several documents such as SOPs and SKs had been made by clinic X. If viewed as a whole, the comparison of readiness in 2021 and 2024 in terms of documents and implementation has increased, but it is still in the partially fulfilled category with a predicted score in 2021 of 41.7% and 65.8% in 2024.

Accreditation policies affect the implementation of accreditation. Policymakers must socialize the accreditation policy to the health services that will carry out accreditation. Accreditation improves the quality of service and staff involvement helps improve quality outcomes. Systematic reviews of health sector accreditation also report improvements in professional development. The challenges that exist in terms of human resources are the high workload and work problems in the previous accreditation. Furthermore, a systematic review of health sector accreditation shows that the cost of accreditation is high for individual organizations. Meanwhile, other studies conclude that the costs incurred to participate in accreditation should be seen as an important investment in improving the quality of health services (El-jardali et al., 2014).

CONCLUSIONS

The achievement of the readiness of the accreditation of medical record units with a predicted score in 2021 of 41.7% and in 2018 of 65.8%. The increase in accreditation readiness can be shown by the existence of documents that have been made according to the elements of accreditation assessment, but the Standard Operational Procedure (SOP) for services and activities at the Medical Record Unit of Clinic X is still in the form of a draft document and has not been ratified by the leadership of Clinic X.

The achievement of accreditation assessments has not been maximized because almost all of the assessment elements that are not yet possessed are the availability of supporting documents.

With this initial assessment, it is still possible to complete the supporting documents so that the achievement of the accreditation preparation score can increase. It is necessary to monitor the evaluation carried out (self-assessment) to find out the position and achievement of the clinic in facing accreditation.

The readiness of the medical record unit still needs to be improved, it can be done by making a checklist of accreditation document needs according to the assessment elements. Then, it is followed up by identifying document needs and identifying documents that have been created, documents that need to be revised, and documents that have not been created. Forming a special accreditation team to prepare for accreditation can help make it easier to identify and complete documents according to the elements of accreditation assessment. Clinics can do several things in the preparation of accreditation documents such as creating a frame of reference first. T

hen determine the method to be used, for example using the questionnaire method or the interview method. The next is to analyze the instrument by recapitulating the results obtained according to the method used. This is quite effective in the processing and fulfillment of documents and meets the assessment elements in accordance with the established accreditation standards.

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